PATIENTS' PROBLEMS: DOCTORS AND THEIR FAMILIES

By Dr. Norman Gold

Delivered at a Meeting of the Medico-Legal Society held on 17th March, 1979 at 8.30 pm at the Royal Australasian College of Surgeons, Spring Street, Melbourne. The Chairman of the Meeting was the President, Mr. S. E. K. Hulme, Q.C.

A paper delivered to this Society in October 1967 by Dr. G. R. A. Syme and Mr. D. W. Rogers dealt with the consequences of medical mishaps. A recent bibliography which was produced by the Department of Health, Education and Welfare of the United States of America, looking only at the English language literature, found under the title "The Physician and Malpractice" no fewer than five hundred and twenty-one citations in the brief period from May 1974 to September 1978. In the U.S.A., "Doctor Bashing" has become an important industry. From this it is not too far fetched to believe that the American Bar Association had been advertising on their T.V. stations the slogan "Support a Lawyer, send your child to medical school".

I do not intend to talk about medical negligence, but will concentrate on the problem of becoming and being a patient either as a doctor or a member of a doctor's family. A myth has grown up that this has some special sinister significance although the literature on this topic is somewhat scanty and much of the information I have acquired has come from my dealings within a professional and social sphere with doctors and their families. On this anecdotal level they have led me to believe that they consider themselves to be a group at special risk in obtaining treatment for their illnesses. Much that is talked about is given credence when it appears in print, either in the medical or lay press. I fear that we are woefully short of facts to confirm or deny this myth that doctors make bad patients and their families get poor medical care.

I intend to discuss some of the papers that have been written about doctors and their families in a prejudiced manner in order to show you how differently one can look at the same factual information. An old Armenian proverb states that he who wishes to tell the truth must have a fast horse well-saddled, and one foot in the stirrup. Since I do not have such equipment to hand, I can only promise to be

"reasonably honest"—a term that Sir James Darling used to chide us with when he addressed this Society in March 1968.

I propose to look at the beginning of the myth by glancing first at the medical student, then at the doctor, special groups of doctors, the doctor's spouse and family. I will mention some of the legislation that has been enacted overseas, both in the United States and the United Kingdom, and I will indulge in some degree of futurology towards the end of my talk.

The Medical Student

I am discussing now the student in general. We have some information about the method in which medical students are selected: no matter what, they must get very good results on their Higher School Certificate or its equivalent. The admission by the various Medical Faculties assumes that the overriding criterion has to be high marks in a certain number of subjects. This assumes that Medicine requires the students to have a tremendous mental capacity. This might be somewhat offensive to the legal members of this Society and I quickly pass on. From studies, it has shown that good results in examinations like the Higher Schools are only useful for predicting the candidates' ability to pass the pre-clinical subjects without difficulty. It can in no way give any help in choosing what will be a "good doctor". This presupposes in the first place that we know what a good doctor is and it fails to pay any attention to the emotional and other needs of a work specification in such a wide ranging series of jobs available in Medicine. The temperament, say, of a medical research microbiologist would not need to be in any way related to someone in general practice or a doctor doing psychotherapy full-time. As an additional hazard, during the seven years period of gestation, during this century incredible changes take place in medical knowledge and the practice and training may become obsolete soon after the Course begins.

If one looks at the reason or reasons why students enter Medicine, a whole wide range are produced. It would be fair to say that while there may be some stated reasons, there must undoubtedly be many unknown ones. There may be a wish to cure, perhaps based on the mimicry due to the early experience the student or his family had with a doctor; there may be a family tradition; the financial reward and the status in our society accorded to doctors could be another factor. A student writing in *The Lancet* last year in the series "If I Were Dean" pondered on the chance of a Selection Board accepting him if he had said that he wanted to make a lot of money. According to some there is an underlying need for omnipotence that drives the student which

has already shown itself by dedication to the Higher School curriculum and good marks in the examination.

It has been said that students should be made aware of their own assets, and also their limitations and responsiveness to human beings. This would be best to prepare themselves for a generalist practice.

In the pre-clinical phase of his studies the student learns the need to distance himself from human beings: the practical anatomy work in the dissecting room can best be undertaken in this frame of mind. (I cannot accept the practice in the University of Aberdeen where students are expected to go to the funeral of the cadavers at the end of the term. This seems a very shocking thing to do to adolescents.) Handling a person's bones, at first awesome, later becomes commonplace due to a protective barrier—a means of reducing anxiety which may later cause difficulties between the student and live patients.

In the clinical field, the student works in the teaching hospital doing things to patients rather than for patients.

Teaching is undertaken by a whole range of specialists as no one doctor can now ever hope to know more than a small fraction of medical knowledge. It has been suggested that these highly skilled and dedicated specialists, carefully selected by the teaching hospital, are responsible for adversely affecting the students' attitudes and cause them to think of patients as 'livers', 'kidneys', 'spleens' or other forms of offal. I am sure that no one could accuse any of these clinical teachers of doing such a terrible thing! However, students do pick up the difference that is made between patients and 'us' and this tends to stay with them for the rest of their lives, albeit to their detriment if they should become ill, because although denial may be a good defence against anxiety it can be life threatening if the denial is persisted in when the facts speak out overwhelmingly against it.

Medical students have a high pass rate: eventually all qualify unless they have become seriously ill with a physical or emotional problem. Apart from these, the only others who drop out in the clinical years are those who become disenchanted with Medicine and take up some other career. Usually they were fairly ambivalent about Medicine in the first place and may have been too immature in choosing the right profession.

The New Doctor

After qualifying, a whole host of new problems arise. There is a rapid departure from a prolonged adolescence perpetuated by the dependence on teachers, the family, the State and sometimes a spouse, which may plunge the new doctor into a whole series of problem areas for which studenthood had not prepared him. It may be very difficult to

accept that senior nursing staff have a considerable amount to teach, particularly in the recognition of seriously ill patients.

It is during the first two years after qualifying that numerous emotional problems arise, as coupled with the medical commitment there may be responsibilities to a spouse and possibly children. During this stage of upheaval numerous changes are going on inside and around the doctor which may adversely affect the work and family field.

Statisticians in the past tended to regard doctors as a homogeneous group. As a group they have been studied in terms of their longevity, and whereas in the early part of the twentieth century in England and Wales they had a higher mortality than other professional groups, after 1949 their health improved.

The statistics for Scotland are difficult to interpret as physicians and surgeons are grouped together as well as dentists and veterinary surgeons. In Denmark, doctors' longevity has improved above other professional groups as has the white doctors' in South Africa, and medical practitioners in New Zealand have shown a similar pattern.

A study of the graduates from Harvard Medical School found that they had a better health record than the male white population. This may have been due to the rigid selection techniques the University employed, but they also found that those who specialized had a lower mortality than non-specialists, and that medical specialists a higher mortality rate than the surgical specialists in the fifteen to twenty-five year period under study, but after this no difference was noted.

Another American study has shown that doctors still had a slightly higher expectation of life than the white general population. Several studies of special groups of doctors have been undertaken. These have been those admitted to hospital with particular illnesses, mainly psychiatric, and these have shown a high incidence of alcoholism and drug dependency.

It has been conservatively estimated that five per cent of adult males in Australia have a drinking problem. As there are just over nine thousand doctors on the Victorian Medical Register and eighty per cent are male, we can assume that three hundred and sixty doctors have a drinking problem.

A North American study of one hundred abstinent alcoholic doctors whose period of sobriety had varied from one to twenty-seven years with a mean of seven years, found that over half of them had been in the upper third of their graduating class, a quarter were in fact in the upper tenth, and only six per cent of the total were in the lower third. They therefore represented very successful students. Nearly three-quarters of these doctors had been institutionalized

because of their alcoholism. This had involved them in six hundred and twenty-seven admissions, the time spent in hospital totalling in all, thirty-nine years. Surprisingly, one-third said that their therapist had refused to discuss alcoholism with them. Forty-eight of the doctors had been arrested no fewer than two hundred and nineteen times in all, and thirty-seven of these had been imprisoned on one hundred and seventy occasions. The reluctance of local policemen to press charges against the over-worked doctor, particularly his own general practitioner who had "taken a drink too many", might have reduced the incidence of arrests quite markedly. Ninety-one of the doctors at the time of the study were working full-time, one had retired completely (he was in his late seventies and had been abstinent for over twenty years), five were semi-retired, and another had left medical practice to become an author.

A conference held in England in 1977 reported that deaths due to cirrhosis of the liver were three times higher among doctors than the population matched for age and social status, so there may be factors other than the ability to pay for the expensive hobby of drinking—(Wilde: Work the curse of the drinking classes). As this illness is usually a measure of alcoholism, these figures in England and Wales cannot be easily ignored.

A study of pathologists in England and Wales during 1955 to 1973 found there were nine suicides which were three times the number expected. Eight had died from lymphoma and leukaemia, which again was three times that expected.

A study of members of the American Society of Anaestheologists during the period 1947 to 1966 showed a higher death rate due to malignancies of the lymphoid and reticulo endothelial system and the suicide rate was twice that of a comparable socio-economic group. While coronary artery disease was the commonest cause of death, it was still lower than the population matched for socio-economic status.

The famous study of smoking habits of doctors in Britain rapidly convinced the doctors that smoking cigarettes was dangerous and in a follow-up study some years later, the researchers were unable to find a group of non-smoking doctors with chronic bronchitis to match those suffering from this condition who were smokers.

In Australia it has been estimated that fourteen per cent of doctors are still smoking, and in New Zealand a limited study there has shown that one-third of the doctors are smoking. Unfortunately, due to some lack of communication they found that fifty per cent of doctors' spouses were smoking.

It has been alleged that anxiety has been the reason for the persistence in smoking and drinking in the medical profession and that

we are supposed to be living in an age of anxiety. Previously, mankind had anxieties about survival due to infectious diseases and climate when deaths of children from now rare conditions were commonplace. Now new anxieties appear to depend on the size of the television screen, the type of swimming pool and various other essentials. Anxiety about driving a motor can be reduced by using the oldest anxiolytic drug known—Ethanol.

Since 1965 the Journal of the American Medical Association has listed in their brief obituaries the causes of death and have given suicide as one of them. This rather shocking habit that the Americans adopted is quite different from the British and Australian style of medical obituary which, even if the doctor had died in front of a group of witnesses at a medical conference by shooting himself, would euphemistically list him as "dying suddenly". The American obituaries have given rise to a large amount of information being made available so that it has been estimated that different groups of doctors have higher suicide potentials. The lowest suicide rate is amongst paediatricians and the highest amongst psychiatrists. This latter group has further been subdivided so that those whose work is in psychoanalysis and individual psychotherapy have been found to have a higher suicide rate than those engaged mainly in organic treatment of psychiatric ills. The numbers themselves are relatively small in some of the specialities so that care must be taken in interpreting all the figures with complete certainty.

The known suicide rate in the United States of America is over two hundred doctors per annum, greater than the output of the whole of the Medical Faculty of the University of Melbourne in one year.

A more up-to-date survey of the obituaries in J.A.M.A. of doctors who died between 1965 and 1968 shows that of those in the group aged twenty-five to thirty-nine, twenty-six per cent had killed themselves.

The attempted suicide rate by doctors is thought to be much less than the average population although the suicide rate is larger.

In a study of the mortality statistics in the United Kingdom, male doctors have a suicide rate of 1.15 of their matched socio-economic group, but at a younger age.

Allowing for the availability of dangerous drugs and the knowledge that the doctor has of their toxicity, it may be that a combination of these two factors is one of the reasons why suicide amongst doctors is much more common then attempted suicide. What is not understood is why the doctor about to kill himself was not recognized, treated, and allowed to work on as a doctor.

In looking at the violent deaths of doctors in the United States from information culled from the obituaries, deaths due to car crashes

in the period 1965 to 1967 were one hundred and twenty-eight; plane crashes fifty-three, in many of which it was the doctor's own aeroplane; twenty-seven were drowned; twenty-one were killed by others, fifty-six were possible suicides and two hundred and forty-nine proven suicides.

A Californian survey published this year dealt with the incidence of tuberculosis in doctors to ascertain doctors at risk, risk prevention, and monitoring of those contracting the illness. There were 6,000 doctors written to; over 4,000 replied. A striking finding that came out was that although tuberculosis remains an occupational disease of doctors, they take few precautions to prevent it. Antituberculosis chemoprophylaxis was shown to prevent more than seventy per cent of active tuberculosis when given to recent tuberculin reactors. It appeared to be one hundred per cent efficient for the few physicians who used it. Two-thirds of all active tuberculosis preceded or coincided with the first known positive tuberculin test. More than half of the doctors known to have recent conversions did not begin chemoprophylaxis and more than one quarter of those who initiated chemoprophylaxis did not complete the course. The value of preserving the tuberculin tests in the United States medical student, however, may not be relevant when two-thirds of tuberculin negative doctors fail to monitor the possibility of recent infection. The criteria for B.C.G. use have been met in the doctor population reported upon. They may not apply to nurses and other health care workers who, in our experience, have been much more compliant with annual skin testing programmes and with chemoprophylaxis. The doctors' failure to implement disease preventing behaviour probably is related to their lack of perceived vulnerability and the press of other priorities. Whatever the reasons, their record with respect to the prevention of noso-comial tuberculosis is drab. A re-evaluation of the teaching of doctors and medical students is in order.

Women Doctors

In the Bible and the classics, women were well recognised as being healers, but it is only recently that women have been allowed to practice Medicine in Great Britain since the Medical Act of 1877. The two exceptions were Dr. James Barry who had been a senior military doctor for many years and gained the rank of Inspector General of Hospitals, equivalent in modern terminology to Major-General. On Dr. Barry's demise it was found that 'he' was a woman and that she had borne at least one child: one can only presume that some time during her military career she must have become more than usually attached

to her trench coat as a British Warm would never have concealed a full-term pregnancy.

The other doctor who became famous was Elizabeth Garrett who studied at the Society of Apothecaries of London after discovering a loophole in their Constitution and qualifying in 1865 before it was closed to women. She became a Dean of a Medical School, a very busy doctor, reared a family and cared for her husband. It is unlikely that the conditions that allowed this to happen in Victorian England will ever be seen again.

It is because of the prejudices against women in Medicine that they have had to be much more subjected to stress than their male counterparts. For a long time, admission to Medical Schools was difficult because it was thought a waste of time to train a girl who would give it up when she got married. Some studies have shown, however, that this pessimism has been unfounded and in recent years the number of female medical students has increased markedly, so that in years to come their conditions of service may be quite different. Certain specialities such as General Surgery appear almost closed to them, but paediatrics, psychiatry, family planning appear to attract many, possibly by default. Many of these women doctors are married to doctors or other health professionals and frequently it is the spouse's career that has taken precedence, and if they have opted to have a family it has left them behind in the training programmes so that their husbands have gained the higher qualifications while they are still baby sitters.

If I might quote from another survey of the obituaries in the Journal of the American Medical Association, it was found that women doctors under the age of forty-five had three times the suicide rate compared with their male colleagues.

A Canadian woman doctor writing last year in the British Medical Journal spoke of how she nearly died due to a ruptured ectopic pregnancy. She had already been to see a gynaecologist at the request of her surgeon-husband. She described graphically her symptoms which had gone undiagnosed by her busy doctor/husband and it was only when a non-medical neighbour came to call and she opened the door to her on all fours that she received the urgent surgical care she required. Her comment was that she was embarrassed about being a patient and reluctant to admit to needing attention, so much so that she dreaded the thought of medical consultation.

Doctors' Families

They attempt to get medical advice from a doctor spouse or parent. Unfortunately this is done without an appointment being

made, often at the end of a busy day when rest and food are required—not further demands on his professional skill. History taking may be limited. Physical examination may be limited or very briefly undertaken. Prescribing often is what is available within the home. If the illness has not cleared within a few hours, the patient may be given different treatment. As the presence of a sick spouse or child is a source of professional embarrassment—particularly as the sick person cannot be put down in the diary to review or visit later on—it is claimed that too little skill is put into the diagnosis and treatment of sickness in the doctor's family. Follow-up appointments may never be made.

Recently some paediatricians have questioned whether they should give medical care to their friends' children. They pointed out the difficulties in obtaining relevant information from the doctor/friend about professional matters because of the embarrassment it causes. They also commented on the fact that parents may expect special privileges. The editor, in a short note introducing the article, comments that the paper "opens a subject rarely discussed in these pages, if, indeed, anywhere".

In another paper, two child psychiatrists have found that in their experience, medical families get less than optimal psychiatric service due to a difficulty in sharing truthful information and because of the deliberate act of minimizing symptoms that medical families have when referring a child for help.

Doctors' Wives—They have usually come from one of the helping professions.

One male medical writer from the U.S.A. has suggested they are almost angelic—however, others are less enthusiastic.

A study of twenty randomly selected case histories of doctors' wives who had been admitted to a psychiatric unit found that thirteen patients had a previous history of admission for psychiatric treatment, mainly for attempted suicide. (The age range was from twenty-seven to fifty years). Eleven had a history of drug and/or alcohol abuse. Here, the doctor/husband was the most frequent source, either prescribing it or allowing it be obtained from his supplies. In thirteen patients they had used drugs for suicidal attempts. They were not all gestures, as in six the result was life-threatening. The most frequently used descriptions of the wives in the clinical records were dependent, immature, histrionic, hostile, manipulative.

Only one of the doctor/husbands had received psychiatric treatment. They were all regarded as competent doctors, but were described as being cold, rigid, undemonstrative. In only one record

was there a note that the sexual relationship between the partners was satisfactory. The wife generally feared that the psychiatrist treating her would ally himself therapeutically on the side of the doctor/husband. Although the therapist considered that conjoint marital therapy was the best form of treatment for most of these patients, in only five was it undertaken. The major resistance came from the doctor/husbands.

In another review of the records of fifty doctors' wives who had received psychiatric in-patient care and on whom there was complete documentation it was found that in only forty of them was there adequate details about the husband. (The wives' age distribution was twenty-five to sixty-two years.) One of the doctor/husbands had been hospitalized for drug abuse, but the rest had no psychiatric history. The husbands were generally described as undemonstrative, perfectionistic, cold, domineering, dependent, a failure as a father and a husband—very similar findings to the previous study.

Twenty-six of the patients complained of their husband's frequent absence from the home, and in sixteen it was regarded as a precipitating factor of the patient's illness. Twelve of the sixteen patients treated for drug abuse had received the drugs from their husbands. Five of the husbands had given their wives medication, in some cases by injection. As a group these women had successfully survived the difficult years of their husband's medical and specialist training in their early years of marriage.

A psychiatrist, in writing about problems in medical and nursing families, pointed out that "bossiness and need to change people" is well nigh universal amongst medical practitioners! This adversely affects the family relationships. He mentions the problem of confidentiality of notes in the family when someone is sick, particularly with a psychiatric disorder. This is a constant source of concern causing anxiety, both to the patients concerned and the treating doctors of medical families.

A study of operations performed on doctors and their spouses in California found that doctors' wives had more operations than other professional groups. Although they were looking only at a limited population under the age of sixty-five, they were concerned that the appendicectomy and hysterectomy rates may well exceed the point of positive benefit/risk ratio.

Problems arising in the treatment of doctors and their families by other doctors appear to be based on a number of things—one is the wish not to bother doctors as they are busy people. The habit of treating one's self and/or one's family without an adequate history and physical examination brings to mind the famous medieval

apothecary's statement—"He who physics himself, poisons a fool". Doctors tend to choose someone to treat them whom they can influence in some way, and in turn the doctor treating tends to feel under scrutiny from the doctor/patient and more likely to feel criticized than if he had a non-doctor/patient. The doctor/patient, in turn, is reluctant to seek a second medical opinion although they may feel things are not going well. The doctor may avoid seeking help early on for fear of being thought of as hypochondriacal, and at a later stage in his symptoms may be so afraid of their seriousness, that he wishes to deny them to himself and others. Since not making a fuss is taught from a very early age, the doctor and the family are made to believe that they should minimize, if possible, any problems they have. Too often the consultation is not a doctor/patient one, but a joint one not giving the doctor/patient full care and follow-up. The task of giving up being the doctor and taking on the role of the patient, assuming a dependent state, is both difficult and apparently painful for most. However, a senior specialist, while on a trolley proceeding to the theatre for a cataract operation, was consulted by a colleague about a serious family problem. The specialist/patient was under the influence of his pre-operative medication and thought that the time and place were both inappropriate for adequate consultation to take place.

Another doctor writing to the British Medical Journal spoke about his typical pains when he had a myocardial infarction and how he had hoped he was not being neurotic. Due to his training he was relieved to think that at the age of thirty-eight he was not neurotic but had just had a heart attack, obviously ignoring that there are octogenarians who have survived from early childhood with their neurotic illnesses and hypochondriasis—a peculiar reflection on our medical training.

In-patient care of medical staff at their own hospitals is possibly dangerous as the doctor is treated differently—may be permitted to prescribe for himself. Staff feel under critical supervision by the doctor/patient. Other patients in the hospital treat doctor/patient in an ambivalent manner.

Because of the difficulties thought to be experienced by doctors in seeking medical help, in Florida in 1969 it was decided to introduce a 'Sick Doctor Statute'. It defines the inability of a doctor to practice medicine with reasonable skill and safety to his patients, because of one or more illnesses. It eliminates the need to allege or prove that a doctor's clinical judgment was actually impaired or that he actually injured a patient.

The Act provides that, prior to Board action against a doctor, there must be probable cause of his inability to practise medicine with

reasonable skill and safety to his patients. The intent of this provision is to protect doctors from harassment by capricious accusations.

If probable cause is shown, the doctor is required to submit to diagnostic physical and/or mental examinations. It is accepted that he has given implied consent for such examination, under this Statute, by using his licence to practice or by registering his licence annually. The doctrine of implied consent is further used in the law to remove privileged communications that ordinarily exist between doctor and patient. A doctor so ordered to examination waives this legal privilege, thus making available to the administrative tribunal records of the examiners' consultation and diagnostic tests, and testimony.

The accused doctor has the right to receive copies of the examining doctors' reports and diagnosis, and there is provision for his taking the deposition of his examiners. Further, his own medical expert may present testimony.

The Board may suspend his licence, and, in addition, place him on probation. The Board may compel a doctor to seek therapy from a doctor designated by the Board, or it may restrict his areas of practice to those in which he is still believed to be competent. Suspension of licensure privileges is specified to be only for the duration of impairment, and the sick doctor is guaranteed the opportunity to demonstrate to the Board that his licence should be reinstated when he is competent to practise again.

A further provision, again protecting the ill doctor, is the guarantee that neither the record of the proceedings nor any unfavourable order entered against him can be used against him in any other legal proceeding, such as a malpractice action, a divorce proceeding, or a suit to challenge his testamentary capacity.

Texas was the next State to follow this legislation, and now in Arizona and Virginia it is mandatory that any registered medical practitioner reports to the Board of Medical Examiners any information he may acquire that tends to show that any doctor may be unable to practise medicine safely. It also provides for civil immunity under the law for any doctor so reporting in good faith. This was brought in because of the failure of peer referral to arrange the necessary help.

In America in 1975 there was a major meeting called by the American Medical Association—"The Disabled Doctor—Challenge to the Profession". A further conference was held in 1977—"The Impaired Physician: Answering the Challenge". Still problems are present. In New York State, licensing of doctors is carried out by the Department of Education.

In Britain last year the Medical Act was changed enlarging the General Medical Council and restructuring the Committees. A

Health Committee now exists apart from the Professional Conduct and Medical Ethics Committee. A Preliminary Proceedings Committee has been set up to receive complaints about doctors and to decide whether or not to send the problem on to the Health Committee or the Professional Conduct Committee for a full enquiry. The Committee can make an Order for a doctor's interim suspension or a conditional registration in order to protect the public. The doctor is given the opportunity to appear before the Committee and be legally represented. If the Health Committee decides that the doctor is seriously impaired by reason of his physical and/or mental condition, it may suspend his registration or make it provisional on him receiving appropriate treatment. No doctor serving on the Preliminary Proceedings Committee can hear the same problem doctor as a member of the Health or Professional Conduct Committee. Appeals to the Privy Council are permitted only on questions of law. It was hoped with this enlightened legislation, that colleagues and families of sick doctors would give up the previous conspiracy of silence for one of constructive compassion.

Crystal Ball Gazing

From what has happened overseas it appears that some changes will take place in Australia. It depends upon the medical profession to take note and act appropriately.

It would seem that the problem of doctors and their families could either be tackled by adopting the principle Samuel Butler wrote about in *Erehwon* whereby people were punished and put into gaol for being ill, or we can adopt a public health approach, i.e. primary, secondary and tertiary, to look more carefully at the health and welfare of doctors and their families.

Perhaps we could start by looking at the process of selection of those who take up medicine and build in some support systems for the medical students so that they can gain the knowledge that they can be ill, so modifying them to understand their only difference from patients whom they see is that no illness has been diagnosed in them—the students at that time—and not that it cannot exist. This would perhaps reduce the desensitizing process whereby students are 'toughened up' against getting too emotional about patients' ills.

The new doctor appears to need better support from his peers, registrars and the senior medical staff.

Some scheme has to be devised whereby doctors and their families can achieve optimal medical care when they are ill and not get 'different' medical care from the rest of the population, as 'different'

means inferior. Perhaps we can still learn something from that vegetarian critic of the medical profession, who survived to a ripe old age in spite of or because of his radical views on health, when he put forward the suggestion that doctors should provide special statistics for the public to see, concerning illness in themselves and their families. In that way we could accept our mortality and not get trapped in the magical belief that unlike the rest of the world, we will not get ill.

From what I have said you understand that most of the ideas about doctors and their families have been based on a few patients looked at by a limited number of doctors. In spite of the multitude of medical papers produced each year, the doctor—the central character—does not appear to be adequately documented. In Victoria it is only since 1972 that mortality statistics delineating medical practitioners have been available and then only up to the age of sixty-four. Due to the apparent over-supply of doctors in Australia it seems unlikely that the National Health and Medical Research Council would now consider allocating any of their sparse resources to a study of doctors. Perhaps they could even justify this by quoting in their reply that since doctors are known to have a high suicide rate, by inactivity the problem of over-supply will soon be corrected. However, taxpayers in general and the University Grants Commission might be more interested, as then they could get a better return on their expenditure which has been allocated for the training of doctors at the expense of the public purse.